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ABSTRACT

It has become increasingly evident that juveniles are the perpetrators of a substantial nunber of sexual assaults. Programs designed to treat these adolescent perpetrators usually have similar goals. They attempt to reduce the youth's risk of recidivism by helping him to recognize his problem, take responsibility for his actions, learn how to control his behavior, reevaluate his attitudes and values toward sexuality and aggression, develop a positive self-concept, learn new social skills, and engage in reeducation and resocialization. In designing programs, several therapeutic and administrative issues must be addressed in the areas of informed consent, family involvement, labeling, segregating sex offenders, staff selection and training, and exit criteria. A review of community based programs and five specific residential programs revealed that, across programs, the educational model was predominant. Treatment techniques included an eclectic combination of role play, psychodrama, gestalt therapy, Transactional Analysis, guided interaction therapy, Rational Emotive Therapy, and behavioral therapy. Program components included family therapy, education in human sexuality, victim awareness, interpersonal skills, anger management, grief work, journal keeping, survival skills, sex-role education, substance abuse work, and general education. (Relevant materials including training resources and lists of programs are appended.) (NB)

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ADOLESCENT PERPETRATOR TREATMENT PROGRAMS: PROGRAM MODELS

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Working paper by Joan M. Abbey, M.S.W. Candidate University of Michigan for Maxey Boy's Training School, Michigan Department of Social Services. April, 1987.

ADOLESCENT PERPETRATOR TREATMENT PROGRAMS

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ADOLESCENT PERPETRATOR TREATMENT PROGRAMS

INTRODUCTION

STATEMENT OF PROBLEM. American society has long considered sexual abuse to be a rare phenomenon. Unfortunately, it is not as rare or infrequent as most people would like to believe it is. Scholars and clinicians over the last decade have uncovered quite high incidence rates which suggest the problem is more prevalent than official statistics, such as the Uniform Crime Report have indicated. Practitioners and researchers have also provided society with clearer insights into the scope of the problem. It has become increasingly evident that juveniles are the perpetrators of a substantial number of sexual assaults. This growing realization is in part due to developments which occurred in the last decade. First, a number of adult sex offender treatment programs were established in the 1970's. Therapists and researchers involved in these programs unearthed alarming information from their clients which revealed clients' involvement in sex offenses in adolescence. The autobiographies of these clients verified what had long been suspected by therapists, that the behavior of a large number of adult sex offenders is patterned on acts that begin in early adolescence. Second, as programs serving victims of sexual assault proliferated, a significant number of clients served by these programs reported their assailant was under the age of 18. As a result of the data accumulated by rape crisis centers and adult offender treatment programs, communities have had to face the reality that their own sons, brothers, and baby-sitters were engaging in sexually deviant and damaging behaviors.

The reasons for treating adolescent perpetrators are many including; community safety, the early onset of deviant behaviors, the possibility of these behaviors increasing in both severity and number of offenses as a perpetrator grows older, the multitude of sexually deviant behaviors, exhibited by a single offender, and the cost effectiveness of early intervention. Most adolescent perpetrator treatment specialists agree that early intervention in compulsive deviant behaviors is useful. Further, when perpetrators are treated in programs that provide the skills and tools for them to identify and manage their sexually inappropriate behaviors they stand a much better chance of controlling their impulses and their assaultive behavior.

.Nationally more than 52 programs have sprung up to respond to the needs of adolescent perpetrators.(1) While the need for early intervention and treatment of adolescent perpetrators is clear, standards for program development and treatment are less clear. This lack of standards is due in part to the relative youth of the discipline of adolescent perpetrator therapy. The treatment of adolescent perpetrators is an infant discipline within the mental health arena. The oldest professionally staffed and operated treatment program for this population was started in 1978 by the University of Washington's Adolescent Clinic, and the oldest residential treatment program has only been in operation for seven years.(2) It was not until 1983 that the C. Henry Kempe Center for the Prevention and Treatment of Child Abuse and Neglect established the Network of Professionals Encountering Adolescent Perpetrators of Sexual Molestation of Children. The Network's newsletter *Interchange* is one of the few sources of support and information for clinicians working with this difficult population.(3)

FOCUS AND ORGANIZATION. The purpose of this paper is to examine a few of the central issues facing clinicians and administrators in designing and implementing treatment programs for adolescent perpetrators. This paper will first offer a synopsis of treatment goals, objectives, and techniques common to most programs. A discussion of several important therapeutic and administrative issues inherent in designing programs is also presented. Following the introduction to general treatment program issues, several residential program models are overviewed. These models were selected for presentation within this document due to the fact that their client population, program setting, agency affiliation and funding sources are similar to Maxey Boys Training School. A brief description of the characteristics of quality community based programs is included as well. The final section of this paper summarizes key concepts presented within the document and introduces recommendations gleaned from reviewing the literature on adolescent perpetrator programs.

TREATMENT

GOALS AND OBJECTIVES.

The obvious goal of treatment is to reduce the risk of the perpetrator repeating his offense. It is important to realize at the outset that psychological treatment will not irreversibly change behavior. Sexually deviant behavior has a compulsive addictive quality much like alcohol or drug dependency, therefore, there is no guaranteed cure. As Roger Wolfe of Northwest Treatment Associates in Seattle points out. "Any behavior that is compulsive, heavily patterned, and ritualized always remains in the behavioral repertoire. It is always there, it can be relearned, re-energized, or reinitiated at any time. You may learn a new behavior that competes with or suppresses the deviant one; you may unlearn it, but you will not erase it."(4)

The exact treatment goals and objectives for perpetrators vary slightly from program to program dependant upon the program's theoretical orientation. However, certain common assumptions regarding perpetrators' sexually inappropriate behaviors exist across programs and therefore, influence program goals. Prior to outlining standard treatment goals it might prove useful to review these common assumptions. First, most clinicians feel that sexual acting out is a complex multidetermined act which "is the product of an interaction between internal psychological determinants (such as, needs, attitudes, defenses, etc.) and external factors (such as precipitating stresses, victim availability, disinhibitors, etc.)"(5) Second, sexual acting out is the result of defects in development. These defects are the consequence of early and long-term neglect, maltreatment, and sexual abuse. Third, sexually acting out is equivalent to symptom formation. As a symptom it is a repetitive behavior which is self-defeating and self-perpetuating. Fourth, by its very nature sexually assaultive behavior is an interpersonal act involving both sexuality and aggression. It is the sexual expression of aggression, needs, and motives that are primarily nonsexual. Finally, to reduce recidivism there must be changes made in the perpetrator's internal psychological state (thinking errors, attitudes, feelings, etc.). Often with adolescents it is also important to change his external environment as well.

As mentioned previously, by and large the goals of adolescent perpetrator treatment programs are the same from program to program with only minor variation. These goals are outlined below, note that the order in which they are presented does not imply a given goal's priority in treatment.

1. To recognize and acknowledge that he has a problem.
2. To accept responsibility for his actions.
3. To understand the thoughts, feelings, events, and circumstances that precede his assaultive behavior and compose his "criminal cycle." (Appendix I.)
4. To learn how to interrupt his cycle when its starts up, and control his behavior by utilizing the tools and procedures learned in treatment.
5. To re-evaluate his attitudes and values towards sexuality and aggression.
6. To engage in a re-education and resocialization process in order to change antisocial attitudes and behaviors into prosocial ones.
7. To acquire a positive self-concept and new attitudes and expectations for himself and others.
8. To learn new social and sexual skills to help cultivate positive, satisfying, pleasurable, and nonthreatening relationships with others.

In the January, 1986 issue of *Interchange* Brent Carlson presented seven objectives for achieving treatment goals. Developed by the Oregon Adolescent Sex Offender Treatment Network these objectives were outlined in a working document entitled, "Formulating Standards for Treatment."(6)

OBJECTIVES

The offender will:

- not deny the sexual offense
- discuss the sexual offense behavior
- not blame others for their choice to offend sexually
- be able to identify their own feelings of victimization
- be able to identify and empathize with the likely feelings of their victims
- be able to discuss some emotional and attitudinal precipitants of the sexual offense behavior
- discuss what situations and emotional states must be considered danger signals in the future and what action steps to take to change such situations

COMPONENTS AND TECHNIQUES.

In the area of treatment program components and techniques there is much more variation across programs. Nevertheless, certain program components are fairly global and several techniques are becoming quite popular with sex offender treatment specialists. Whether they be found in residential or out-patient settings all treatment programs contain the following components reeducation, resocialization, and group and individual counseling. (Appendix II.) Many programs also contain a family treatment component. An analysis of family involvement issues will be presented later in this paper. The following discussion of these elements is by no means comprehensive, but should provide the reader with some insight into treatment formats currently in use.

Almost without exception the primary treatment modality is group treatment which operates on a guided self-help and mutual aid concept. Group treatment seems to be the modality of choice, because it allows services to be provided to a large number of clients when staff resources are limited. Furthermore, it makes sense from a therapeutic stand point when working with involuntary clients whose major problem is in the area of interpersonal relationships. Most importantly, the self-help group treatment model has proven to be effective in controlling compulsive behavior (i.e. Parents Anonymous, Alcoholics Anonymous).

REEDUCATION. Clinicians across the country have found that perpetrators for the most part are uniformed and misinformed about human sexuality. In addition perpetrators attitudes and values in regard to appropriate sexual behavior are generally based on negative stereotypes. Reeducation therefore, always includes sex education. Group discussions often focus around myths and misconceptions about human sexuality, the anatomy and physiology of sex, sexual roles, gender and identity issues, reproduction, variations in sexual behavior, fantasies, values, attitudes, common questions and concerns. Along with sex education reeducation components typically address the issue of understanding what constitutes sexually assaultive behavior and the internal as well as external forces that prompt the perpetrator to engage in this behavior. Learning to identify and interrupt what Haversack calls the "crime cycle" is crucial in treating perpetrators.(7) The purpose of this type of education is to help the perpetrator control their behavior and to dispel some of the rationalizations, self-deceptions and projections of responsibility onto others that are often used to avoid recognizing their problem. Victim personalization is often included in reeducation components. Educational efforts directed toward developing victim empathy usually focus on the impact of the offense on the

victim. Both the long-term and immediate effects of the offense on the victim are addressed.

RESOCIALIZATION. Due to maltreatment and other adversities encountered during their early years most perpetrators are ill equipped to handle life's demands adequately. Especially problematic for them are interpersonal relationships due to their social skills deficits. Resocialization components typically explore problems in communications and the formation and maintenance of relationships based on trust, intimacy and reciprocity. Management of aggression and stress are usually central topics in resocialization components. Perpetrators are helped to appreciate the long-term negative consequences of the use of aggression, and trained in the use of assertiveness techniques. In general resocialization efforts are aimed at facilitating perpetrators' feelings of self-control, so that they have less of a need to control others in an abusive and exploitative fashion.

COUNSELING. Although groups are the treatment modality of choice individual sessions are often necessary for crisis intervention purposes or to prepare the adolescent for group work. Counseling components address the issues surrounding the perpetrator's own victimization experiences, feelings of abandonment and rejection by their families. Haversack reports that 90 percent of the clients treated in the Hennepin County Home School's Sexuality Therapy Group have been physically, sexually and emotionally abused. "They really hold onto their rage for their parents."(8) Many programs work to enhance the adolescent's self-esteem through activities which are restitutive in nature. Engaging in restitution activities will become a more viable treatment technique if House Bill No. 4240 introduced by Representatives Van Regenmorter, Bullard et al. successfully passes through the Michigan legislature.[1]

Implementation of these treatment components is generally carried out through concrete, behavioral and action oriented techniques. This is due to the fact that perpetrators in general and adolescents particularly tend to act out their problems and not talk about them. Groth recommends that both individual and group treatment components be time limited and that treatment be broken into distinct stages each with a specific focus and objective. Such a task oriented approach he feels is best suited for the short attention span and low frustration level of adolescents. By allowing for immediate feedback and reinforcement and keeping treatment techniques at a concrete task oriented level the adolescent feels he is accomplishing something and that the treatment experience is helpful.(9)

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[1] H B No. 4240 Sec. 44 (1) encourages the court to enter orders of restitution at the dispositional hearing.

Common concrete techniques include having the juvenile write an autobiography, keeping a thinking error log, roleplaying, video instruction and feedback, sociodrama and/or psychodrama, modeling, having the offender make restitution to the victim, and behavioral conditioning exercises. Without a doubt behavioral procedures are the most controversial and have also proven to be the most effective with adult perpetrators. Behavioral techniques such as, masturbatory satiation or verbal satiation, covert sensitization, olfactory aversion and orgasmic reconditioning are used the most often by adult and adolescent treatment programs.(Appendix III.) However, caution must be taken in employing these techniques with children, especially in closed residential settings.(10) The following section will explore some of the legal and ethical issues in the use of behavioral treatment with adolescents.

THERAPUETUC MILEAU ISSUES.

INFORMED CONSENT

In general courts have found that children have fewer Constitutional rights available to them then adults (Bellotti v Baird, H.L. v Matheson).(11) While it may be true that minors have fewer rights than adults they still retain some rights. In 1973 (Morales v. Turman) the Supreme Court held that children in a state training school or other institutions cannot be subjected to cruel and unusual punishment, such as drugging and excessive solitary confinement.(12) It is therefore, necessary for anyone professionally involved in treating clients in an involuntary setting to meet the issue of informed consent head on. No where is this truer than in treating adolescent sex offenders. This is due to the experimental and sometimes invasive techniques employed in treatment programs. "Use of behavior modification techniques has grown rapidly in the treatment of sex offenders."(13) These procedures are particularly suited for use because they focus on changing behavior and the offense usually involves overt behavior. However, in the court's eyes, behavior modification techniques may provoke legal and ethical questions revolving around mind control and cruel or unusual punishment. In order for sex offender therapists to be legally safe they should fully disclose treatment information to clients and obtain informed consent.(Appendix IV.)

The courts and statutes speak of "informed" consent, but exactly how much information constitutes informed consent is still being interpreted by the courts. At a minimum informed consent should imply giving the client information about the basic nature of the treatment and any risks involved. Content of the information presented to the person should include 1) the diagnosis or purpose of the treatment, 2) the prospects for success or benefits to be derived from the treatment, 3) the risks involved, 4) the nature and duration of the treatment, 5) possible disadvantages if the treatment is not under taken, 6) and alternative methods of treatment.(14)

The next logical step would be the development of a written contract between the therapist and adolescent. The concept of a contract between the client and the therapist has long been the procedure with voluntary clients, but it should be expanded to include all therapeutic relationships regardless of the client's legal status. Treatment contracts should serve the following purposes: contain a statement of possible detrimental side effects of the treatment, especially if the treatment is experimental. (Treating sex offenders is by definition experimental.); act as a record of appropriate and realistic treatment goals negotiated by the therapist and client; the clinician's and the client's expectations of themselves and each other. It should be

noted the courts will be apt to interpret such contracts narrowly. Nevertheless, it is good clinical practice to obtain informed consent from the juvenile in the form of a therapeutic contract.

Groth and others advocate the use of contracts for engaging the client in the treatment process and as a standard for evaluating the perpetrator's progress.(15) According to Longo the perpetrator's ability to identify his problems and assist in the development of treatment goals for inclusion in the contract is a good indicator of his prognosis.(16) The contracting process and the interviews leading up to its development can resolve some of the issues relevant to confidentiality and family involvement. Groth describes how confidentiality is handled by the Sex Offender Program at the Connecticut Correctional Institute, thusly. "First we inform the inmate that nothing he discloses in treatment is confidential, with regard either to the treatment staff or to the administration. There is no confidentiality or secrecy."(17) It is assumed that the nature of confidentiality as it relates to the client-therapist relationship is discussed with the perpetrator. It is especially important that the adolescent be aware of the legal requirements placed on the clinician regarding the reporting of child abuse in the adolescent's home.(18)

FAMILY INVOLVEMENT

Practitioners from every theoretical orientation agree that involving the adolescent perpetrator's family in the treatment process is vital to success. Family based treatment is necessary to "eliminate family dynamics that may support or tolerate the abusive behavior".(19) Common family structures found by clinicians are chaotic or enmeshed. Isaac's reports that most of the parents involved in the Closed Treatment Unit "Parent Support Group" at the Lookout Mountain School "exhibit many of the same characteristics as their adolescent -- denial, minimization, externalization, rationalization, anger, and resentment."(20) The majority of adolescent perpetrator treatment programs have some form of parent involvement component. In community based programs it is often a criteria for acceptance into the program. The staff of PHASE have identified "five pervasive problem areas that required focused family work: role clarification, power imbalance, family individuation, communications, and family esteem".(21) Rogers and Thomas urge the careful exploration of interpersonal relationships within the family so that issues such as anger, hostility, mistrust, and feelings of emotional abandonment arising among family members are identified and resolved.(22)

Family treatment components take several forms. Parent support groups which are presented as a service offered to address some of the

identified needs of parents' of adolescent sex offenders is the most common format used by residential programs. In addition to groups many programs offer individual or marital therapy. Family therapy incorporating all family members or appropriate subgroups is also a popular modality.

The Personal Socio-Awareness Program in Minnesota has an interesting element in their family treatment program whereby the families participate in an intensive two-day experience called the "Family Journey." Families learn about the range of sexual expression in large group sessions where information is presented informally and through audio-visual materials. Each seminar participant then has an opportunity to react to the large group sessions in small groups with unrelated adults and children. The Family Journey concludes on the last day with a worship service, family dinner, and evaluation.(23)

LABELING

Labeling of the perpetrator and of sex offense specific treatment programs poses a thorny treatment issue. In so far as visiblity within the institution poses an obstacle to participation, treatment groups can be given "face saving," yet, accurate titles, such as "aggression management" as opposed to being called sex offender groups. There are three schools of thought pertaining to the therapeutic implications of labeling adolescents as sex offenders. Margolin of the Lincoln Regional Center's High Risk Offender Program is representative of the view that supports labeling adolescent perpetrators. She states that labeling the adolescent as a High Risk Offender (HRO) "makes it significantly harder for the offender to push his assaultive history to the back of his *own* mind. It acts as a symbolic focus of treatment which expresses in one condensed idea the nature and depth of the problem at hand."(24) On the other hand is the perspective expressed by Linda Tschirhart Sanford, victim advocate and author. Knopp reports Sanford as saying, 'The adolescent offender usually has not had enough varied sexual experience to *choose* child molesting as the preferred sexual expression. . . and while the offender should be accountable and treated for the offense, it is clearly inaccurate and not at all productive to label him."(25) Many programs take a more middle of the road approach and encourage the adolescent to look at his behavior as a developmental problem which must be acknowledged and worked on. Thus, perpetrators are required to openly articulate their problem, but discouraged from developing a self-image as a sex offender.

SEGREGATING SEX OFFENDERS

Most residential treatment programs do not provide separate quarters for adolescent perpetrators. Instead they live in the general population and meet in a separate offense specific group at least once a week. Programs which do have separate quarters cite many advantages to such arrangements. Haversack reports that segregating perpetrators allows them to be more comfortable in discussing sexual issues and makes it more difficult for adolescents to con child care staff regarding specific treatment assignments.(26) Some of the disadvantages of having perpetrators living among the general population reported by Longo are that "the potential for breach of confidentiality is greatly increased; and. . . the potential for a self-help atmosphere among offenders in the program during free or leisure time is greatly reduced."(27) For many of the residential programs described later in this paper, housing of the perpetrator in separate quarters is an important element in the treatment process.

STAFF SELECTION AND TRAINING

It goes without saying that adolescent perpetrators are a difficult population to work with. Furthermore, the subject matter which must be dealt with in the treatment process is of a nature that many therapists are uncomfortable with. Staff recruitment and training procedures need to allow for these considerations. A strong emphasis is placed on initial and on-going training for program staff in all the program models reviewed. Groth considers human sexuality education for staff working with perpetrators as vital.(28) (Appendix V.) The preferred staffing pattern for most programs is to have a balance of male and female staff, so that the perpetrator can learn to relate to both male and female role models in a positive fashion. Many adolescent perpetrators have misperceptions of appropriate male behavior and require a healthy mature adult to model appropriate methods of expressing emotions. Perpetrators generally also need opportunities for interactions with healthy mature females to broaden their perceptions of female roles and behaviors.

EXIT CRITERIA

In the absence of clear legal standards for admission and release from sex offender treatment programs these decisions are left up to personnel within juvenile institutions or removed totally from their control by the length of the juvenile's commitment set at disposition. The lack of program release standards is especially problematic for sex offender therapists. Therapy by definition implies a resolution or "cure" is offered to the person

engaging in the treatment process. The implication that sex offenders can be "cured" by "treatment" places a tremendous burden on the treatment staff.(29) In fact, because of the chronic nature of the offending behaviors, there is never a hope of "curing" the adolescent perpetrator. Instead there is only the hope of controlling or reducing the behavior.

Most programs use several measures to evaluate the perpetrator's progress. Administering all the same tests that were done on entry into the program is the most common evaluation procedure.(Appendix VI.) The use of a check-off system to monitor which individual and program goals have been accomplished is another possible method, as is the use of pre- and post-attitudinal surveys. Some programs follow the adolescent in the community for several years, at six month intervals a staff person will contact probation authorities, the youth, and his family to check on the adolescent's progress.

For clinicians working in correctional settings the issue of what constitutes successful completion of the program is complicated when parole review boards are involved. If a perpetrator believes that program staff have influence over his release from the institution, one may expect him to engage in manipulative persuasive behavior to convince the staff of his rehabilitation. It is perhaps best to inform perpetrator's from the outset the therapist's role in parole decisions and to persuade the adolescent that his problem is one he will continue to grapple with long after release from the program and institution. Recognizing the chronic nature of his problem is not enough however, and continued out-patient treatment should be made a condition of parole. Many experts recommend the intensification of specialized offense specific services when a perpetrator is placed in a community facility or on parole. As Edward Elwin, Executive Director of the New York State Division of Parole observes, 'No matter how good a program may be provided and used inside, its effects can be obliterated following release if there is no significant aftercare.'(30) Therefore, an important component of any residential treatment program will be out-referral, community placement, and follow-up.

THE MODELS

The number of adolescent perpetrator treatment programs has continued to grow since the University of Washington started the first one in the fall of 1975. There are more out-patient community based programs than residential ones in the United States, and unfortunately fewer than one fifth of the states provide any form of services.(31) Michigan is not blessed with a wealth of community based programs, but their numbers are growing. As mentioned previously out-referral and community placement will need to be an integral component of MBTS's treatment program.

COMMUNITY BASED PROGRAMS

In seeking out community based placements for an adolescent perpetrator several factors are vital as to whether or not the adolescent can make use of the program. Most obvious is the aspect of access, if the program is located in a geographic area the perpetrator cannot get to, if the program has an extensive waiting list, or if its group meeting times are inconvenient for the perpetrator a referral to the program will not be useful. Less obvious but equally important is compatibility between the program's philosophy, treatment modality and techniques with that of MBTS's program. It is hoped that the following outline of the characteristics of quality community based treatment programs will assist program staff in identifying programs to establish out-referral agreements with. This will allow there to be a continuum of treatment which will support and build upon the work done with the adolescent while in residence.

PROGRAM CHARACTERISTICS

A perpetrator group which meets weekly for a minimum of two hours

Family therapy

Marital or individual therapy for parents

Individual therapy for the perpetrator, if needed

Parent education and/or support groups

A minimum of three program phases addressing:
social skills development,
education issues, and
coping in an unstructured environment

Highly qualified and trained program staff

Quality, reliable assessment and evaluation tools

Adequate program resources and staff support to be effective

On-going training and skill development activities for staff

Special seminars/retreats for perpetrators and families

Program length of at least six to nine months, preferably with on-going support groups, similar to Alcoholics Anonymous

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RESIDENTIAL PROGRAMS

The five programs described herein are in host settings and have client populations that are similar to MBTS. They do however, vary somewhat, from the "open" Hennepin County Home School's Sexuality Therapy Group in Minnesota "to the most secure program in the country, The [sic] Sex Offender Group at the Closed Adolescent Treatment Center in Colorado."(32)

SEX OFFENDER THERAPY PROGRAM
Echo Glen Children's Center
Snoqualmie, Washington

The Sex Offender Therapy Program at Echo Glen Children's Center is the oldest residential adolescent perpetrator program in the country. It was established with the assistance of staff from the University of Washington's Juvenile Sex Offender Program in 1980. Echo Glen Children's Center is a coed state institution located on a 690 acre campus like setting. Their Sex Offender Therapy Group prefers not to treat highly aggressive rapists or low risk offenders who can be treated in the community. Treatment modalities differ according to the needs and capabilities of the perpetrator. Adolescent's with significant behavioral problems or intellectual limitations are not admitted to the group, but offered individual treatment instead. Perpetrators are not segregated. However, cottage programs differ at Echo Glen and three or four of the 11 cottages are used for perpetrators due to the relevance of their programing and staff. Labeling of the adolescent perpetrator is discouraged by the staff. Further, the staff consider one year

in residence to be the minimum amount of time necessary to begin the change process for serious offenders.

Treatment begins in the cottage program, the perpetrator is encouraged to talk about his offense history with his counselor and "possibly the cottage residents."(33) Group therapy is the primary treatment modality. The group leaders try to be directive and structure the group sessions without being authoritarian. They provide specific tasks that facilitate the members to interact, give positive feedback to each other, make decisions, self-disclose, be spontaneous and creative. Techniques used include a variety of structured tasks that promote physical and personal involvement, role plays and psychodrama. The message in the methods used at Echo Glen is to take control over your own (perpetrator's) life through the task and action oriented process offered.

The Sex Offender Therapy Group meets for approximately 15 sessions. The first session focuses on building trust and cohesion, the members are given an assignment to prepare to discuss their sex-offense histories. Over the next two or three sessions the members listen to each others histories. The group leaders are not confrontive. but supportive and empathic at this point. During the following four or five sessions sex-role stereotypes, attitudes about power in social situations and other issues are explored. When the group has meet seven or eight times group rules and goals are reevaluated. Each member's investment in the group and willingness to take risks is explored. A major focus at this point is victim empathy, guided visualization, role plays and other socio-drama techniques are used to help the perpetrator recall how the victim acted and looked. During the last four sessions, the groups' work is to identify their motivations for sexually acting out. Members are helped to recognize danger signs that they are in a high risk situation and taught how to handle themselves. The sex offense specific treatment program does not have a formal parent involvement component, but the youth are encouraged to discuss their treatment with their parents.(34)

SEX OFFENDER TREATMENT PROGRAM
Blue Spruce Treatment Unit
Lookout Mountain School
Golden, Colorado

The Blue Spruce Treatment Unit is a rural residential facility. The court adjudicated youth it serves are committed for a minimum of one and a maximum of two years. They range in age from 16 to 18 years. Designed to serve repeat and violent offenders who are diagnosed as immature conformists according to the interpersonal maturity diagnostic system, residents with a history of sex offenses are treated in the Sex Offender

Treatment Program(STOP). Adolescent perpetrators are not segregated from the rest of the population.

A multidisciplinary team shares responsibility for the STOP. The team consists of a Youth services Counselor, four Youth Services Workers, and one teacher. The team has weekly meetings to review individual progress and plan strategies. In this way each offender is evaluated every 10-12 weeks. The team uses the Problem Oriented Record System (PORS) as means of comprehensively evaluating the perpetrator. In brief PORS consists of a problem list on which the perpetrator's problems are listed by staff and an asset list which notes strengths to be used in problem resolution.

The STOP meets biweekly and there are several other components to the treatment program. Individual counseling is used as an adjunct to the group. Members have two individual session per week with their Youth Services Worker. Family counseling and communication is the responsibility of the individual counselor who is given support by the Sex Offender Group cofacilitators. The extent of the families involvement hinges on an evaluation of the relative importance of the family's dynamics in the offender's treatment, the family's proximity and their ability to attend family visits and treatment sessions, and their willingness to take part in treatment. Perpetrator's attend biweekly dorm groups to discuss a range of issues that are not necessarily sex offense specific. Social Development Classes are run by Youth Services Workers to teach a range of skills from assertiveness to employment skills.

The facilitators of the Sex Offender group promote a trusting nonthreatening atmosphere. The clients are approached from the perspective of acceptance and support even though they are exhibiting intolerable behavior. Appropriate confrontation is also used within this framework. The group sessions focus on: disclosure and discussion of sex offenses and other violent offenses, family issues, the perpetrator's own victimization experience, chronology of perpetrator sexual experience, interpersonal relationship patterns, values clarification victim empathy, sexual fantasies, life stressors contributing to offense behavior and sexual identity issues.(35)

SEXUALITY THERAPY GROUP
Hennepin County Home School
Minnetonka, Minnesota

The Hennepin County Home School (HCHS) is a rural, coed, open institution serving adjudicated youth. "All most all of our clients are developmentally disabled" reports Haversack "the point at which their development is arrested is the concrete operational thought level"(36)

Adolescent perpetrators are housed separately from the rest of the population. Staff feel this affords them an opportunity to get to know the adolescent better and to become more comfortable relating to him. Further, they feel programing especially around anger and intimidation issues can be intensified.

In order to be admitted to the Sexuality Therapy Group (STG) the adolescent must be willing to be involved in family counseling, participate in a preadmission interview with STG staff, and sign a contract agreeing to work on 10 stipulated areas. Haversack relates that they will not "deal with an adolescent who is denying his guilt, we tell them to get their attorney to take it back to court if they are not guilty."(37) The adolescent perpetrator treatment group meets twice-weekly and is geared to adolescents whose commitment to HCHS is for nine months. Family Therapy is started right away or at the same time the group treatment starts, individual counseling is not offered. However, the STG program is supplemented by the regular cottage program components which include daily therapy groups, family therapy, and recreation. Week long seminars on human sexuality are held in each cottage twice a year. The topics covered during these special workshops range basic anatomy to sexual values and sex roles.

The STG program consists of six stages which are outlined below.

Stage 1. Power and Control: The treatment staff's goals at this stage are to; 1) raise client's anxiety level, 2) identify client defenses so they are ineffective, and 3) get the client to the point where he realizes what he is doing isn't working to meet his needs.

Stage 2. Confusion/Frustration: Haversack reports that at this stage most of the treatment work is done by child care staff. The adolescent is seen as feeling defenseless and overwhelmed with guilt, fear and shame. "The clients are scared."(38) Staff goals are to; 1) support the client, 2) provide for the safety of the clients, 3) build their esteem, and 4) help the client reach a point where he can ask for help.

Stage 3. Dependency On Us: At this stage the client realizes he can depend on other people. Treatment goals at this stage are; 1) for the client to develop a trusting relationship, 2) generalize the trust, 3) learn about feelings, and 4) learn new ways of meeting his needs.

Stage 4. Victimization/The Offender As A Victim: During this stage the client shares the abuse he suffered, and risks the pain, hurt, and trauma of being a victim. Staff goals are; 1) have the adolescent stop blaming self, 2) believe that he deserves to be loved, 3) stop taking his hurt and anger out on others, and 4) understand the offense.

Stage 5. Honesty With Feelings And Sexual Acting Out: Clients during this stage have an overwhelming need to be more honest about his commitment offense and other offenses. The goals for the program at this point are; 1) to know everything about his sexual acting out, 2) obtain help for all new victims identified, and 3) clean up legal aspects of new offenses.

Stage 6. Developing Empathy: Learning the value of helping others and becoming less ego-centric is the focus of this stage. Treatment goals are: 1) for the adolescent to be aware of others: 2) to take other's feelings and rights into account before acting; 3) understand the victim's trauma, pain, and anger; and 4) to take care of others.

Haversack offers several words to the wise for therapists working with adolescent perpetrators. First, if a child has been badly abused at home he may fear for his personal safety or that of the therapists during family sessions. This fear may inhibit therapeutic progress, HHCHS counters this by having security personnel available outside the treatment room door, if necessary. Second, sharing the victim's artwork (depicting the assault) with the perpetrator often convinces him of the anger, hurt, and trauma experienced by the victim. Third, in doing role plays she advises that the actual offense should never be acted out, but the role play should be stopped just short of the offense. Fourth, if the group members are acting out and being disruptive, as opposed to attending to the group's work, end the session early. Thus, derailing the group members' efforts to control the situation. Finally, she cautions that when perpetrator's are relating their sex offense history to the group. Staff should be alert for signs that other group members are becoming aroused by the story.(39)

INTENSIVE CHANGE SEX OFFENDERS' PROGRAM
Maine Youth Center
South Portland, Maine

The Intensive Change Sex Offender's Program (ICSOP) is offered in Cottage I. Cottage I. houses 30 highly aggressive 13 to 19 year olds of which 20 to 30 percent are sex offenders. This four year old program has a distinctly different treatment approach than the other programs described thus far. The focus of treatment at ICSOP is on changing the thinking patterns of the adolescents. The program is highly structured. Promoting an atmosphere conducive to learning, the staff encourage the notion that every moment should be used constructively. Activities, such as watching television, playing cards, or reading comic books are discouraged; instead emphasis is placed on reading, writing, and discussion. The treatment program at ICSOP is based on the work of Samuel Yochelson and Stanton

Samenow, using a model developed by William Glasser and William Powers.(40)

The program operates from the perspective that from an early age the inmates have been developing a criminal personality based on thinking errors. They have developed a 17-point checklist of "errors" that are common among the Cottage I population.

1. Victim stance
2. "I can't" attitude
3. Lack of concept of injury to others
4. Failure to put oneself in the place of others
5. Lack of effort
6. Refusal to accept obligation
7. No concept of trust
8. Unrealistic expectations
9. Attitude of ownership
10. Irresponsible decision making
11. Failure to plan ahead or think long range
12. Flawed definition of success and failure
13. Fear of being put down
14. Refusal to acknowledge fear
15. Anger used to control people
16. Power tactics
17. Pride or refusal to back down

Adolescents participating in the program are trained to keep records of their daily thinking patterns and to recognize their "errors." Perpetrators are also taught a series of five graded "deterrents" to assist in the elimination of inappropriate thinking patterns. Deterrent 1, called the "poison deterrent" allows the adolescent to become conscious of the fact that all thoughts about crime or serious irresponsible behavior are dangerous. Deterrent 2, teaches the adolescent in-depth how to get rid of the criminal thought through reasoning. Deterrent 3, this involves learning mental strategies that can come into action when negative thinking occurs. Deterrent 4, requires the adolescent examine his conscience and the wrongs he has done. Deterrent 5, is when these four processes become automatic and few criminal thoughts occur. In order for the perpetrator to keep track of his "thinking errors" and corrective actions youth carry a "redirection book" with them at all times. Every time an irresponsible thought surfaces, the adolescent takes out his pocket sized spiral notebook and jots down a responsible thought to replace the irresponsible one. When used properly the "redirection book" may have anywhere from 20 to 150 entries a day. From time to time the perpetrators are asked to identify the 10 most successful or often used redirection behaviors noted in his book.

Other program techniques include, the reflection hour, self-inventory, intensive examination groups, dialogues and moral inventory, as well as

intensive seminars and workshops. A brief description of these program components follows. The "reflection hour" is held every morning, during this hour the adolescent records as much of his daily thinking as he can He looks for thinking errors or irresponsible thoughts which accompany his emotional and behavioral processes. Each day the staff read these reflection hour reports and make comments about the entries before returning the report to the adolescent. Staff may extrapolate material from the reflection hour reports to use during the ICSOP sessions. During the reflection hour the adolescent also carries out a self-inventory to reconstruct his thinking patterns through applying the five deterrents mentioned previously. A small "intensive examination" group meets three times a week to discuss their reflection hour reports and apply the corrective process. During one of the weekly meetings staff address sexuality issues and socially acceptable sexual behaviors. To develop victim empathy the adolescent carries out a moral inventory in which he lists the injuries he has caused to others and himself. Another victim empathy exercise which is occasionally used as a discipline measure is called "dialogues." These "dialogues" are usually written communications between the offender and victim, families, drugs, sexuality or other issues. The most remarkable aspect of the Cottage I program is that while many of the adolescents in the program are labeled learning disabled staff report that 'We have yet to have a boy in three years who couldn't, within one or two months, do this written work.'(42) Utilizing techniques which emphasize the individual's responsibility in learning the staff hold week-end long seminars that teach difficult to understand subject matter. Families and perpetrator's also participate in day long workshops which are educational.

The program's family component takes the form of family/offender groups as well as follow-up sessions with individual families. Families are also involved in seminars and workshops facilitated by the staff.(43)

THE SEX OFFENDER GROUP
The Closed Adolescent Treatment Center
Denver, Colorado

The Closed Adolescent Treatment Center(CATC) is a highly structured, secure program for female and male adolescents who have been labeled "untreatable" or extremely sociopathic. The CATC program is housed in a maximum-security, one story, red-brick "cottage" and serves 26 youth (male And female) ranging in age from 12 to 21 years old.have been on average in nine other institutions before entering the program. The program is geared to youth who are committed for an average two year sentence.(44) Staff daily convey the message to program participants that 'no matter what you do, staff will never give up on you.'(45) This is reflected in the fact that staff refer to these violent offenders as "students." At the same time staff put

tremendous pressure on the adolescent to change his aggressive behavior. Two requisites to making this change happen are adequate numbers of staff who are willing and able to set and enforce limits and an intensive program structure.

There are 26 staff involved in the CATC, each perpetrator is assigned a staff coordinator who is aware of his special needs. When it is deemed an appropriate time to admit the perpetrator into the Sex Offender Group he will be selected to participate. In preparation for this the adolescent must keep a personal journal. When he is admitted to the program he is placed on "Entry Level" and spends the first two and a half days in his room reading the treatment program and house rules, and practicing assigned calisthenics. The adolescent is not allowed to join the peer population, instead groups of staff and peers visit the youth in his room and explain the program to him. These visitors tell him that in three days he will be ready to meet with the full group and explain to the group the behaviors which resulted in his commitment. Most of the time the adolescent is left alone in the hopes that he will develop anxiety about entering the group. During the last few days of the first week he comes out of his room to join in "structured peer raps."(46)

When he finally joins the full group he sits in a circle with 25 peers and 10 to 18 staff members. Both peers and staff confront his denial and minimization in recounting his offense. The adolescent is informed that when he learns that he must own up to the responsibility for his crime, reverse his negative values, and makes it known to his peers that he understands the program he will then be allowed out on the floor to join in the peer culture. This acceptance automatically results in his entry into "Team II."(47) If the adolescent continues to deny his crimes he is placed on a "Disciplinary Team" and returned to his room to work on specific negative behaviors.(48) At the "Team III" level the adolescent is expected to have identified and worked on his problems enough to be able to function adequately within the institution. By the time he has reached "Team IV" the adolescent is charged with testing his ability to handle himself off grounds, beginning to develop release plans and helping others. At this level the adolescent is expected to help his peers and model responsible behavior for them. The "Release Team" member is required to have his release plans completed and begin testing of his skills on the outside. The CATC program is geared to accomplish three overall goals; 1) teach the offender how to handle his own behavior, 2) become concerned with the behavior of his peers, and 3) learn how to handle himself outside of the institution.

The program is based on three treatment modalities: Guided Interaction Therapy (GIT), the Interpersonal Maturity Diagnostic System (I-Level System), which is used to match staff and peers and to classify and

identify specific treatment approaches to use with a given adolescent. At CATC they also use a "Team" and "Point System" to provide feedback on behavior and to determine a youth's placement. Like the Blue Spruce Treatment Unit at the Lookout Mountain School the staff at CATC use the Problem Oriented record System(PORS) to record the goals and outcomes of treatment.

Knopp describes the GIT groups as being similar to positive peer culture. The staff and offenders are assigned to either the instrumentals or expressives group. With the exception of the Sex Offender Group(SOG) all treatment activities are conducted in homogeneous groups of instrumentals and expressives. Staff are evaluated on the basis of their work records and habits to determine their placement in either the instrumental or expressive group. These groups meet every weekday for two hours. In weekly business meetings the GIT groups make decisions about passes, level promotions, and special contracts. Further, the GIT process is carried out 'on the floor' all the time. In the GIT groups the staff's role is to provide models and facilitate the process. Early in the group process the adolescent perpetrator is expected to focus on the adolescent's life. The youth's personal history is written down and read to the group. Another early focus of the groups is developing victim empathy and understanding of the impact of the crime on the victim. Techniques used include victim offender meetings and confrontation. Not all victims are willing and/or able to take part in such meetings. This author's experience with teenage incest victims and adult rape victims, is that those victims who are willing and able to confront their assailant find it to be a very beneficial experience. Generally it serves as a from of catharsis , guilt relief, and as a prevention education activity for the victim. This is especially true in stranger rape situations, because the victim learns why she was targeted for assault. The staff at CATC refer to this empathy building phase as "grief work" and note that it may take anywhere from six months to two years to work through depending on the offender. If at the end of this period the staff feels a major catharsis is necessary, a full psychodrama may be carried out in three acts. The events preceding the offense, the actual offense, and a summing up are roleplayed out, the psychodrama is followed by a discussion which centers on concrete plans for where the offender goes from here. The focus then moves from inner directed activities to learning about values, human sexuality, dealing with substance abuse, family, and other problems to prepare the youth for readmittance to the outside world.

Once the adolescent has exhibited some new behaviors faithfully kept a journal, and displayed his readiness to change his lifestyle he is admitted into the SOG The group is facilitated by coed therapists and meets once a week for two hours. Both instrumentals and expressives are mixed in these groups of three to five adolescents. In the group "strict confidentiality" is

observed and the adolescents are responsible for raising therapeutic issues. The SOG is less structured than the GIT groups, and the staff promote a more nonthreatening atmosphere. In the SOG the work revolves around the issues of sexual aggression, power and control and the adolescent's offenses and inadequacies (real and perceived). The adolescent's journal is a primary treatment technique. The youth make entries in the journal daily. Entries provide insight into the issues the perpetrator is grappling with and his stimulus/response pattern. Specifically the youth is asked to record "his sexual fantasies, particularly the ones he masturbates to; share what kinds of situations have made him angry and how he dealt with them; report about the conflicts he has with others and his perceptions of those persons; indicate which experiences made him feel controlled, helpless, or inadequate; and describe the interactions he has with females and males in the course of the day."(49) The SOG cofacilitators read the journals once a week and write in comments. These comments assist the adolescent in identifying "the patterns he uses to express anger, power, and control."(50) As with the Hennepin County Home School program the group works to identify each perpetrator's "crime cycle." Once the cycle is identified, it is confronted and work on learning new thinking patterns begins. The focus is on new nonviolent alternatives to coping with stress and the adolescent's ability to make intelligent decisions which shape his life. Other issues dealt with by the group include anger, rejection, abandonment, victim empathy, the depersonalization of females, and the perpetrator's own victimization. The staff feel it is important that the victimization experience be worked through, but not allowed to be used as an excuse for the adolescent's behavior. Further, staff report that two big issues are the adolescent's relationship, or lack thereof with his father and fear of homosexuality.

> 'Their biggest fear is the fear of homosexuality, because their identity is so screwed up. If they deal with daddy, then they have to deal with their victimization. Since male victims usually get erections and may sometimes ejaculate when they are victimized, the whole guilt and concern they have about sex every time they get an erection -- and adolescents have those concerns anyway -- makes it all the more difficult to deal with daddy because it brings up the homophobic fears.'(51)

Two other aspects of the CATC program are worth mentioning. The manner in which reentry into the community is handled and family involvement. After family issues are explored in GIT family therapy is implemented dependant upon the families willingness and ability to be involved. The process of reintroducing the adolescent to the community is a gradual one with several elements. Staff provide support for the adolescent who is engaged in work release, and brief outings in the community, efforts are made to bring the adolescent into contact with all key players in the

community such as, social service workers, police, and school personnel. A community services worker works with the adolescent for six months or more after his release. Program staff are fortunate to have the option of going to the court and asking for a six months to two year extension of commitment if the staff feel an adolescent needs further treatment.(52)

SUMMARY AND RECOMMENDATIONS

SUMMARY

There is wide spread agreement that the adolescent perpetrator's behavior is influenced by cultural and social factors, as well as being brought up in a dysfunctional family. Generally the adolescent perpetrator uses minimization and denial, is uniformed about consensual sexual activity, has low self-esteem, lacks skills to cope with anger, aggression and feelings of powerlessness constructively, lacks social skills, has been abused/neglected, and has suffered from the negative effects of sex-role stereotyping.(53) Several treatment programs address the issues of powerlessness and low self-esteem through strong peer cultures. However, across programs the educational model is the predominant mode. The treatment techniques used are an eclectic combination of role plays, psychodrama, gestalt therapy, Transactional Analysis, guided interaction therapy, Rational Emotive Therapy, and behavioral therapy. Program components include family therapy, education in human sexuality, victim awareness, interpersonal social skills, anger management, grief work, journal keeping, survival skills, sex-role expectations education, substance abuse work, and general education.

RECOMMENDATIONS

Several concepts predominate the literature regarding the treatment of adolescent perpetrators. The need of these youth for nurturing relationships with adult males and clarification of the adolescent's confusion over sexuality. While many program offer traditional "sex education" only the Minnesota models are exemplary in the manner in which the adolescent is educated about the positive, pleasurable, and appropriate sexuality. Acknowledgement and instruction regarding the positive aspects of sexuality need to be addressed in treatment programs.

According to Knopp, Longo, Jackson, and others the following items are crucial in implementing and evaluating sex offender treatment programs.

1. Each adolescent needs a complete individualized assessment and treatment plan.
2. Each high risk residential perpetrator needs a prolonged period during his treatment when he can begin to test his newly acquired insights and control mechanisms in the community without the potential for affronting or harming members of the wider community.

3. Each adolescent perpetrator needs access to a post-treatment group or other follow-up care for assistance in maintaining a safe lifestyle.
4. Training opportunities should include not only treatment staff, but agency administrative personnel so that sex offense issues may be thoroughly understood and the commitment to address these issues strengthened.
5. Programs need to develop program evaluation criteria which include at a minimum these criteria.
    a) Program continuity and consistency in treatment.
    b) A multiple treatment modality approach.
    c) A drug and alcohol treatment component.
    d) A family involvement component.
    e) Follow-up and community reentry services.(54)

All of these elements are important considerations in designing and implementing treatment programs for adolescent perpetrators. Groth suggests that the most vital element is therapists who are able to confront the adolescent, are comfortable giving orders, setting limits and boundaries, can define and enforce sanctions, demand responsible behavior, and utilize leverage points to control the youth. In order to achieve success these intervenors must be able to simultaneously offer support, concrete help, consistency and persistent outreach.(55)

NOTES

1. Irene Jackson, A Preliminary Survey of Adolescent Sexual Offenders in New York: Remedies and Recommendations. (New York Safer Society Press, 1982.) 11.

2. Fay Honey Knopp, Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions. (Syracuse, NY: Safer Society Press, 1982.) 40-41.

3. Fay Honey Knopp, The Youthful Sex Offender: The Rationale and Goals of Early Intervention and Treatment. (New York: Safer Society Press, 1985.) 12.

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5. A. Nicholas Groth, "Treatment of the Sexual Offender in a Correctional Institution." in The Sexual Aggressor. Eds.Joanne G. Greer and Irving R. Stuart, (New York: Van Nostrad Reinhold Company, 1983.) 165-166.

6. Brent Carlson, "Formulating Standards for Treatment A Working Document." Interchange (The Cooperative Newsletter of the Adolescent Perpetrator Network, January 1986.) 15

7. Gail Haversack, "The Treatment of Adolescent Sexual Offender/Abusers." Address at 1986 Michigan Statewide Conference on Child Abuse and Neglect.. Ann Arbor, Michigan. 4 November 1986.

8. Ibid.

9. Nicholas A. Groth and William F. Hobson, "The Dynamics of Sexual Assault." in Sexual Dynamics of Anti-Social Behavior. Ed. Louise B. Schlesinger and Eugene Revitch, (Springfield, IL: Charles C. Thomas Publisher, 1983.) pp.159-172.

10. Emeline M. Otey, and Gail Ryan, Adolescent Sexual Offenders: Issues in Research and Treatment. (Washington, D.C.: U.S. Department of Health and Human Services, 1985. 21.

11. Bellotti v. Baird, 428 U.S. 132, 96 S. Ct. 2857, 49 L. Ed. 2d 844 (1976) also H. L. Matheson et. al., 450 U.S. 398, 101 S. Ct. 1164, 58 L. Ed.. 2d 862 (1981)

12. Tom Croxton, "Lecture on the Civil Rights of Minors." School of Social Work University of Michigan, January 1986.

13. Bohmer, 13.

14. Ibid. 6.

15. Groth & Hobson, 268.

16. Robert E. Longo, "Administering a Comprehensive Sexual Aggressive Treatment Program in a Maximum Security Setting." in The Sexual Aggressor. Eds.Joanne G. Greer and Irving R. Stuart, (New York: Van Nostrad Reinhold Company, 1983.) 16.

17. Groth, 17.

18. MCL 722. 621 - 722.623 entitled, Child Protection Law

19. Joyce N. Thomas and Carl M. Rogers, "A Treatment Program for Intrafamily Juvenile Sexual Offenders." in The Sexual Aggressor. Eds.Joanne G. Greer and Irving R. Stuart, (New York: Van Nostrad Reinhold Company, 1983.) 130.

20. Connie Isaac, "Parental Involvement in Adolescent Sex Offender Treatment." in Interchange (The Cooperative Newsletter of the Adolescent Perpetrator Network, January 1986.) 5.

21. Knopp, Remedial Intervention in Adolescent Sex Offences: Nine Program Descriptions. 69.

22. Thomas & Rogers, 135

23. Knopp, Remedial Intervention...Program Descriptions. 60.

24. Leslie Margolin, "Treatment Model for the Adolescent Sex Offender." in Journal of Offender Counseling, Services & Rehabilitation. (The Haworth Press,) Vol. 8(1/2) Fall/Winter 1983. 8.

25. Knopp, Remedial Intervention...Program Descriptions. 27.

26. Knopp, The Youthful Sex Offender: The Rationale and Goals of Early Intervention and Treatment. 22.

27. Longo, 179.

28. Jackson, 52.

29. Bohmer, 15.

30. Jackson, 61.

31. Knopp, Remedial Intervention...Program Descriptions. 35.

32. Ibid. 36.

33. Ibid. 92.

34. Ibid. 91-102.

35. Jackson, 84-87.

36. Haversack, 4 November 1986.

37. Ibid.

38. Ibid.

39. Ibid.

40. For more information about these approaches see, S. Yochelson and S.E. Samenow, The Criminal Personality, Vols. I & II (New York: Jason Aronson, 1977) and W. Glasser and W. Powers, Stations of the Mind: New Directions for Reality Therapy (New York: Harper & Row, 1981.) Knopp, 104.

41. Ibid., 105-106.

42. Ibid., 114.

43. Ibid., 103-116.

44. Jackson, 48.

45. Knopp, 118.

46. Ibid., 124.

47. Ibid., 124.

48. Ibid., 124.

49. Ibid., 132.

50. Ibid., 132.

51. Ibid., 133.

52. Ibid., 134.

53. Jackson, 47.

54. Robert E. Longo, "The Adolescent Sex Offender Background and Research Perspectives." in Adolescent Sexual Offenders: Issues in Research and Treatment. Eds. Emeline M. Otey and Gail Ryan, (Washington, D.C.: U.S. Department of Health and Human Services, 1985.) Chapter 3. 144.

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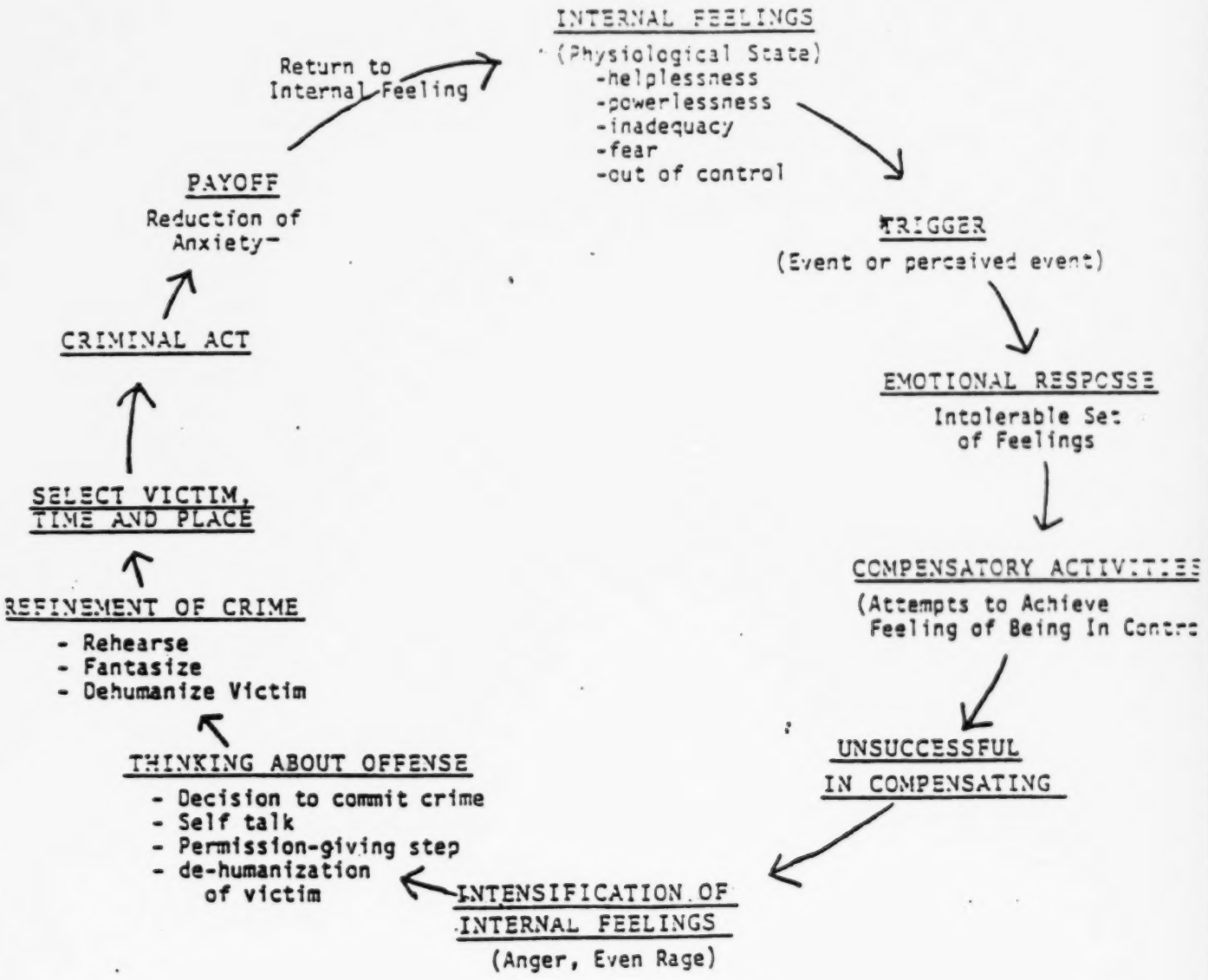
55. Groth & Hobson, 268.

APPENDIX I

CRIME CYCLE/CHAIN OF EVENTS*



* Handout distributed by Haversack during address at 1986 Michigan Statewide Conference on Child Abuse and Neglect.

APPENDIX II.

THE BEHAVIORAL ASSESSMENT AND TREATMENT OF SEX OFFENDERS*

PROBLEM AREAS	TREATMENT METHODS	ASSESSMENT METHODS
Arousal variables		
Excessive arousal to deviant stimuli	Aversion suppression methods 1. Covert sensitization 2. Electrical aversion 3. Odor aversion 4. Chemical aversion 5 Biofeedback-assisted suppression 6. Satiation	Penile recordings Self-report Clinical interviews
Deficit arousal to nondeviant sexual stimuli	Generation of arousal to nondeviant cues 1. Masturbatory conditioning 2. Exposure 3. Fading 4. Systematic desensitization	
Social skills deficits		
Heterosocial skills	Heterosocial skills training	Behavioral role-playing procedures
Assertive skills	Assertive training	Self-report inventories
		Clinical interviews
Sexual behavior		
Sexual dysfunction	Therapy	Sexual inventories
Sexual Knowledge	Sex Education	Sex education test Clinical interviews
Cognitive/social		
Attitudes Perception Discrimination		Burt scale

*Excerpted from "Treatment and Evaluation Issues with the Mentally Retarded Sex Offender." Murphy, Coleman and Haynes. in the Sexual Aggressor. Eds. Greer & Stuart.(pg. 31) The above scale was modified by Murphy, et.al. for use with mentally retarded offenders. It is derived from a behavioral model developed by Gene G. Able , Department of Psychiatry Columbia University Medical School and Director, Sex Offender Treatment Program New York State Psychiatric Institute for use with adult sex offenders. Murphy et. al. postulate that the model will and should be modified as the knowledge base regarding the treatment of sex offenders grows. Further, they invite adaptation and use of the model.

APPENDIX III

ASSORTED BEHAVIORAL TREATMENT TECHNIQUES

A Basic Handbook of Simple Treatments*

1. Orgasmic Reconditioning. a. What is it? Orgasmic reconditioning, sometimes called masturbatory conditioning or reconditioning, is a counter conditioning procedure . . The goal of the procedure is the reprogramming of the sexual deviant's masturbatory practices. The result of successful treatment is that nondeviant stimuli come to elicit sexual arousal but deviant stimuli do not.

b. When do you use it? Orgasmic reconditioning should be used with those clients whose assessment data reveal very low nondeviant arousal and very high deviant arousal.

2 Olfactory Aversion. a. What is it? This procedure is a type of aversive conditioning in which an unpleasant event is made to follow an undesired behavior. Olfactory aversion involves the pairing in time of extremely noxious but harmless odors with presentations of deviant sexual stimuli . . . the effect of the treatment is to suppress deviant arousal. Concurrently maintained levels of nondeviant arousal will be largely unaffected by the intervention.

b. When do you use it? Olfactory aversion should be used with those clients whose assessment data reveal very high level of both deviant and nondeviant arousal.

3. Verbal Satiation. a. What is it? The well-documented observation underlying verbal satiation is that the continuous performance of a behavior in the same stimulus situation will eventually lead to a cessation of that behavior. The procedure requires the repetitive emission of deviant fantasies, with the result that the fantasies lose their power to elicit deviant arousal. Like olfactory aversion, the effect is specific to deviant arousal and nondeviant arousal is usually not affected by the treatment.

*Excerpted directly from "How to Build and Operate a Behavioral Laboratory to Evaluate and Treat Sexual Deviance." by Laws and Osborn, in Sexual Aggressor. 1983. pp325-329

APPENDIX IV

SAMPLE CONSENT FORM

CHILD PROTECTION --SPECIAL UNIT
INTRAFAMILY CHILD SEXUAL ABUSE/JUVENILE ABUSER TREATMENT PROJECT

PERMISSION FOR EVALUATION AND TREATMENT

I hereby give consent to the Children's Hospital National Medical Center and its employees to evaluate _____ for acceptance in treatment and to
Name of Client
provide such treatment and counseling as deemed advisable and necessary in the Intrafamily Child Sexual Abuse/Juvenile Abuser Treatment Project.
I am aware that the practice of counseling and mental health treatment is not an exact science and I acknowledge that no guarantees have been made as to the results of the evaluation, treatment, and counseling.
In the event that _____ has been referred by court order, I
Name of Client
understand that Children's Hospital National Medical Center and its employees will furnish that court with a report of the results of the evaluation and, if he/she is accepted for treatment, with periodic reports of his/her progress in treatment. Such reports will be disclosed only as permitted by the District of Columbia Mental Health Information Act of 1978.

Signed _____ Signed _____
Client Parent or Guardian

Age _____ Relationship _____

Date _____ Date _____

Witness _____

APPENDIX V.

TRAINING RESOURCES*

This list of training resources is partial at best. In addition to the organizations listed here both the Prison Research Education Project (PREAP) and the Adolescent Perpetrator Network at the C. Henry Kempe Center have data banks, publications, and other resource information. Further the staff at most of the treatment programs inventoried in Appendix VII. may be willing to educate and train interested individuals or groups in their approach and techniques. It is suggested that if any of the models described in this paper have components that interest MBTS that they contact these programs directly for additional information.

Forensic Mental Health Associates (FMHA)
3 Ireland Road

Newton Center, Massachusetts 02159
A. Nicholas Groth, Ph.D., Director of Training
H. Jean Birnbaum, B.A., Executive Director

(617) 332-00228

FMHA offers continuing education and training through professional seminars, in-service staff training, etc. For further information contact the following persons closest to your geographical area:

Connecticut: Michael N. Dunaj, 183 Bilton Road, Somers, Connecticut 06071
(203) 749-9183

Massachusetts: H. Jean Birnbaum, 3 Ireland Road, Newton Center, Massachuset 06071 (617) 332-0228

Maryland: Linda Canfield Blick, 3013 Weisman Road, Wheaton, Amryland 20902
(301) 949-3960

Oregon: Robert E. Longo, 2660 Greenway Drive N.E., Salem, Oregon 97301
(503) 378-6078

Texas: Sue James, 9551 Sophora Drive, Dallas, Texas 75249
(214) 296-6798

California: Lois A. Norling, P.O. Box 3014, Anaheim, California 92803
(714) 637-7749

Additional faculty includes: Ann W. Burgess, R.N., D.N.Sc.; A. Nicholas Groth, Ph.D.; Suzanne M. Sgroi, M.D.; William F. Hobson, M.S.; and Eileen Glancy, M.S.W.

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Golden, CO 80402

Connie Isaac and John Davis

The Redirecting Sexual Aggression, Inc., is a private non-profit corporation, providing services to professionals, agencies, and appropriate clients in the areas of sexually aggressive behavior. The goal of the corporation is the development and implementation of programs, modalities and strategies for the identification and treatment of juvenile sexual aggressiveness. The corporation provides consultation and training to people working with sexually aggressive juveniles and/or their victims. The corporation provides interested persons and programs with information relating to the development and the implementation of both individual and group treatment programs designed for the juvenile sex offender

Forensic Mental Health Service

111 Huntington St.

New London, Connecticut 06320

Peter Loss, A.C.S.W. & Jonathan E. Loss, M.A.

(203) 447-1128

The Forensic Mental Health Services of Connecticut is a private agency supported largely by client fees. In addition to providing services to adult and juvenile sex offenders, victims of sexual assault, and their families; the staff at FMHSC provide education services for other professionals and agencies.

Oregon Mental Health Consultants (OMHC)

1290 Fir Street South

Salem, Oregon 97302

(503) 371-6432 or (503) 585-9289

Oregon Mental Health Consultants provide education and training for professionals and agencies in the areas of power, anger, sexuality issues, and present intervention strategies.

*This information was extrapolated from Knopp's Remedial Intervention in Adolescent Sexual Offenses(1982) and the Adolescent Perpetrator's Network Notebook (1984).

APPENDIX VI

SAMPLE PROGRAM RELEASE CRITERIA
LUTHERN SOCIAL SERVICE OF MINNESOTA*

STEPS AND TASKS TOWARD COMPLETING P/SA PROGRAM

1) Presenting sexual behavior patterns and related patterns are viewed by all concerned as either not occurring and/or within sufficient control of the adolescent
and he is demonstrating a growing ability to make wise decisions regarding these behaviors.

2) Owns the presenting behaviors.

3) Has integrated himself into the group and the treatment process to the extent that he feels and demonstrates an ownership of and control of his own treatment.

4) Participates in all phases of treatment.

5) Claims and uses time in group and in family sessions.

6) Moves from a more passive, dependent, irresponsible, helpless relationship to himself and his family to one that is more assertive and responsible.

7) Appears -- where possible to be more actively involved with his family.

8) The other areas of his life are more positive -- i.e. school, friends, etc.

9) Is achieving an understanding and acceptance of his sexuality from a wholistic positive standpoint including his own maleness, sexual integrity and sense of personhood.

10) Able to enjoy and not fear his fantasies and distinguish them from his behavior.

11) Examines his presenting sexual behavior, identifies its meaning and roots and shares his knowledge with his whole family.

12) He and his family actively improve their communications and work together on family issues.

13) Parents and other family members are open in their sessions, identifying feelings and able to accept each others' differences and looking to their own responsibility towards the family and each other.

*Evaluation criteria used by the Personal Social Awareness Program a community based program in Minneapolis. Excerpted from Knopp's Remedial Intervention in Adolescent Sexual Offenses (1982).

APPENDIX VII

ADOLESCENT SEX OFFENDER TREATMENT PROVIDERS

This roster is compiled from several source books published by the Prison Research Education Project (PREAP) It includes the most recent listing published by PREAP in 1985. Programs listed offer group and other treatment services for adolescent perpetrators. Asterisks denote residential programs.

ARIZONA

ADOLESCENT SEX OFFENDER TREATMENT
Youth Services Bureau, Inc.
2333 North Third St.
Phoenix, AZ. 85004
Contact: Theron Weldy

JUVENILE SEX OFFENDER * PROGRAM
Adobe Mountain School
P.O. Box 35,000
Phoenix, AZ 85069
Contact: Paul S. Duda

CALIFORNIA

AMADOR COUNSELING CENTER
P.O. Box 271
Ione, CA 95640
Contact: Gary Lowe

ADOLESCENT SEX OFFENDER PROGRAM
P.O. Box 952
San Jose, CA 95108
Contact: Hank Giarretto

CHILD ABUSE PREVENTION COUNCIL
P.O. BOX 2243
El Centro, CA 92243
Contact: Peggy R. Devay

CHILD SEXUAL ABUSE TREATMENT PROGRAM
929 Koster St.
Eureka, CA 95501
Contact: Ron Kokish

CHILD SEXUAL ABUSE TREATMENT PROGRAM
Family Counseling Service of Coachella Valley
82-380 Miles Ave
Indio, CA 92201
Contact: Pat Marzicola

CHILD & FAMILY THERAPY CENTER
12100 Alhambra Ave.
Martinez, CA 94553
Contact: Donald J. Cotton

CHILD SEXUAL ABUSE TREATMENT PROGRAM
Mendocino Co. Mental Health Services
564 S. Dora
Ukiah, CA 95482
Contact: Garry Flint

DAVID CORWIN, M.D.
11 Moraga Way #3
Orinda, CA 94563

FAMILY SUPPORT PROGRAM
University of California at Los Angeles
Neuropsychiatric Institute C9-933
760 Westwood Plaza

FORENSIC SERVICES GROUP
718 Alhambra Blvd.
Sacramento, CA 95816
Contact: Richard Paul Mahoney

Los Angeles, CA 90024
Contact: Virginia Cruz

GROUP THERAPY FOR ADOLESCENT SEX OFFENDERS
426 Pennsylvania Ave.
San Diego, CA 92103
Contact: Larry Corrigan

INTERACTION
925 W. Hedding
San Jose, CA 95126
Contact: Stewart B. Nixon

MARSHALL PROGRAM**
Southern Reception Center/Clinic
13200 S. Bloomfield Ave.
Norwalk, CA 90650
Contact: Saul Neidorff

SERENDIPITY DIAGNOSTIC & TREATMENT CENTER**
6441 Matheney Way
Citrus Heights, CA 95610
Contact: Robert Elliot

SPARK
Children's Institute International
711 S. New Hampshire
Los Angeles, CA 90005
Contact: Bonnie Yankowitz

YOUTH TRAINING SCHOOL**
15180 Euclid ave.
Chino, CA 91710
Contact: Otis Brantley

INCEST TREATMENT OF ADOLESCENT OFFENDERS
1127 13th St.
Modesto, CA 95353
Contact: Susie Winston

JUVENILE INTERVENTION EDUCATION & PREVENTION PROGRAM
165 E. Lincoln Ave.
Escondido, CA 92028
Contact: David McWhirter

POSITIVE INTERACTION
1041 East Green St. Suite 206
Pasadena, CA 91106
Contact: W.W. Robinson

SEX OFFENDER GROUP**
Wintu Intensive Treatment Program
3001 Ramona Ave.
Sacramento, CA 95826
Contact: Rick Jefferies

YOUTH OFFENDER GROUP
2575 Harris
Eureka, CA 95501
Contact: Mike Yeager

OAK COUNSELING PROGRAM**
Preston School of Industry
201 Waterman Rd.
Ione, CA 95640
Contact: Gary Lowe

COLORADO

ADOLESCENT YOUTH SEX OFFENDER PROGRAM
Moffat Co. Social Services
221 W. Victory Way
Craig, CO 81625
Contact: Nancy Newport

CLOSED TREATMENT UNIT**
Lookout Mountain School
Golden, CO 80401
Contact: Connie Isaac & John Davis

CLOSED ADOLESCENT** TREATMENT CENTER
3900 S. Carr St.
Denver, Co. 80465
Contact: Vicki Agee

BLUE SPRUCE TREATMENT** UNIT
Lookout Mountain School
Golden, CO 80401
Contact: Tom Leversee

ADOLESCENT BOYS GROUP
Arapahoe County D.S.S.
5334 S. Prince
Littleton, CO 80166
Contact. Judith Powers-Smith

WASHINGTON, D.C.

JUVENILE ABUSER TREATMENT PROGRAM
Children's Hospital
111 Michigan Ave. N.W.
Washington, D. C. 20010
Contact: Paul Mitchell

FLORIDA

A & A PROFESSIONAL
COUNSELING ASSOCIATION
1490 W. 49th Pl.
Hialeah, FL 33012
Contact: William R. Samek

ADOLESCENT SEX OFFENDERS
PROJECT
Advocate Programs, Inc.
2206 N.W. 27th Ave.
Miami, FL 33142
Contact. Robert A. Ameo

GEORGIA

CHILD AND FAMILY COUNSELING CENTER
114 Hospital Dr.
Warner Robins, GA 31093
Contact: Mary Doby

IDAHO

KOOTENAI TREATMENT ASSOC.
2110 Ironwood Pkwy. #208
Coeur d'Alene, ID 83814
Contact: John Farley

SPECIAL CARE UNIT**
N. Idaho Children's Home
Lewiston, ID 83501
Contact: Mark Hopper

INDIANA

CHILDREN & ADOLESCENT TEAM
S. Indiana Mental Health &
Guidance Center
207 West 13th St.
Jeffersonville, IN 47130
Contact: Connie Gutherie

HUMAN SEXUALITY PROGRAM
Southlake Center for Mental
Health
8555 Taft St.
Merrillville, IN 46310
Contact: Marcella Wachowiak

IOWA

PERSONAL/SOCIAL AWARENESS
PROGRAM
Catholic Social Service
315 W. Pierce St

LOUISIANA

EDWARD SCHWERY
3456 Cleary Ave
Metairie, LA 70002.

Council Bluffs, IA 51501
Contact: Danielle Griffin

MAINE

THE INTENSIVE CHANGE SEX OFFENDERS** PROGRAM
Maine Youth Center
675 Westbrook
S. Portland, Maine 04106
Contact: David Berenson

MASSACHUSETTS

SEXUAL ABUSE TREATMENT UNIT
Coastal Community Counseling Center
482 Washington St.
Braintree, MA 02184
Contact: Lynn Sanford

VALLEY COUNSELING ASSOCIATION
175 State St. Room 303
Springfield, MA 01103
Contact: William Hobson

MINNESOTA

CENTER FOR BEHAVIOR THERAPY
606 24th Ave. S.
Minneapolis, MN 55454
Contact: William W. Duffy

RELATES
Center for Behavioral Development
740 E. Superior St.
Duluth, MN 55802
Contacin: Stephen Olmsted

NEXUS**
5915 Eden Prairie Rd.
Minnetonka, MN 55343
Contact: Jane Matthews

THE MALE ADOLESCENT SEX OFFENDER GROUP
Storefront Youth Action
7145 Harriet Ave. S.
Richfield, MN 55423
Contact: Mike Wolff

SEXUALLY RESPONSIBLE TEENS
The Center for Parents & Children

MARYLAND

THE CHESAPEAKE INSTITUTE
10315 Kensington Pkwy #213
Kensington, MD 20895
Contact: Linda Canfield Blick

SEXUAL ASSAULT DIVERSION PROGRAM
53 River Pl.
Dedham, MA 02026
Contact: Patricia Nigrelli

NORTHLAND MENTAL HEALTH CENTER
215 S.E. 2nd Ave.
Grand Rapids, MN 55744

PHASE
East Communities Family Center
1709 N. McKnight Rd.
Maplewood, MN 55109
Contact: Michael O'Brien

PERSONAL SOCIO-AWARENESS PROGRAM
Lutheran Social Services of MN
2414 Park Ave. S.
Minneapolis, MN 55404
Contact: William Seabloom

PORT OF OLMSTED CO.**
2112 E. Center St.
Rochester, MN 55901
Contact: Ronald Omdahl

SEXUALITY THERAPY GROUP**
Hennepin Co. Home School

1015 7th Ave. N.
Moorhead, MN 56560
Contact: Nate Larsen

14300 County Rd.
Minnetonka, MN 55343
Contact. Gail Haversack

NEBRASKA

HIGH RISK OFFENDER PROGRAM
The Lincoln Regional Center
P.O. Box 80499
Lincoln. NE 68501
Contact. Leslie Margolin

NEW JERSEY

WARREN COUNTY SEX ABUSE TREATMENT TEAM
3223 Front St.
Belvidere, NJ 07882
Contact: Alice Carducci

SEXUAL ABUSE TREATMENT PROGRAM
Family Guidance Center of Warren County
21 W. Washington Ave.
Washington, NJ 07882
Contact: Terry Powell

NEW YORK

THE JUVENILE SEX OFFENDER PROJECT
St. Anne Institute
160 Main St.
Albany, NY 12206
Contact: Richard Hamill

MacCORMICK SECURE YOUTH** CENTER
South Rd.
Brooktondale, NY 14817
Contact: Kay Scharoun

CHODIKEE SECURE CENTER
RD I-N. Chodikee Lake Rd.
Highland, NY 12528
Contact: Howard Holanchock

OHIO

SERVICES FOR PHYSICAL & SEXUAL ABUSE
Eastway Mental Health Center
400 Wilmington Ave.
Dayton, OH 45420
Contact: Joan M. Evans

OREGON

WASHINGTON COUNTY ADOLESCENT SEX OFFENDER PROGRAM
1665 S.E. Enterprise Circle
Hillsboro, OR 97123
Contact: Jenna Coleman

TONI FARRENKOPF, PH.D & ASSOCIATES
2256 N.W. Pettygrove
Portland, OR 97210

RESPONSIBLE ADOLESCENTS
& PARENTS GROUP
Morrison Center
3355 S.E. Powell
Portland, OR 97214
Contact: Judy Steinberger

CHILD & ADOLESCENT SECURE**
TREATMENT PROGRAM
Oregon State Hospital
2600 Center St. N.E.
Salem, OR 97310
Contact: Robert J. Benning

THE SEX OFFENDER UNIT**
Oregon State Hospital
2600 Center St. N.E.
Salem, OR 97310
Contact: Robert E. Freeman Longo

PENNSYLVANIA

TREATMENT OF YOUNG SEX OFFENDERS WITHIN THE CONTEXT OF THE FAMILY
Philadelphia Child Guidance Clinic
34th and Civic Center Blvd.
Philadelphia, PA 19104
Contact: Ruth Sefarbi

SOUTH CAROLINA

BIRCHWOOD SEX OFFENDERS PROGRAM**
5000 Broad River Rd.
Columbia, SC 29210
Contact: Wallace Meggs

WASHINGTON

SEX OFFENDER PROGRAM**
Maple Lane School
20311 Old Highway 9 S.W.
Centralia, WA 98531
Contact: Kathleen McBride

JUVENILE SEX OFFFENDER
PROGRAM
Adolescent Clinic #CD287
University of Washington
Hospital
Seattle, WA 9810
Contact: Caren Monastersky

SEX OFFENDER THERAPY PROGRAM**
Echo Glen Children's Center
33010 S.E. 99th St.
Snoqualmie, WA 98065

JOHN COLSON
West 508 6th Ave.
Spokane, WA 99204

DRIECUS ASSOCIATES
West 1609 Garland
Spokane, WA 99205
Contact: Betty McQuirt

SEX OFFENDER TREATMENT
Division of Juvenile
Rehabilitation
Mailstop OB-32
Olympia, WA 98504
Contact: Judy Ramseyer

GREENHILL SCHOOL
P.O. Box 600
Chehalis, WA 98532
Contact: Kathleen McBride

The Prison Research Education Action Project (PREAP) maintains nationwide files of agencies and individuals serving adolescent and adult sex offenders. For more information write to: PREAP, Shoreham Depot Road, Orwell, Vermont 05760; or phone (802) 897-7541

The Adolescent Perpetrator Network also maintains files of national and international programs serving adolescent perpetrators which they make available to Network members. For more information write to: Gail Ryan, Adolescent Perpetrator Network, C. Henry Kempe National Canter for the Prevention and Treatment of Child Abuse and Neglect, 1205 Onieda Street, Denver, Colorado 80220